THOMSON HEALTHCARE

Quality Technical Assistance Strategy for MFP

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MFP Quality Requirements

- Have a *Quality Management Strategy* consistent with the 1915c Appendix H requirements
- Have aa 24-hour *back-up system* and monitor its use and effectiveness
- Implement and monitor *risk assessment and mitigation process* for all program participants
- Have an *incident management system* and use it to monitor Health and Welfare of participants on an on-going basis
- Address each in your Operational Protocol

Today is a PREVIEW

Of Quality TA in MFP

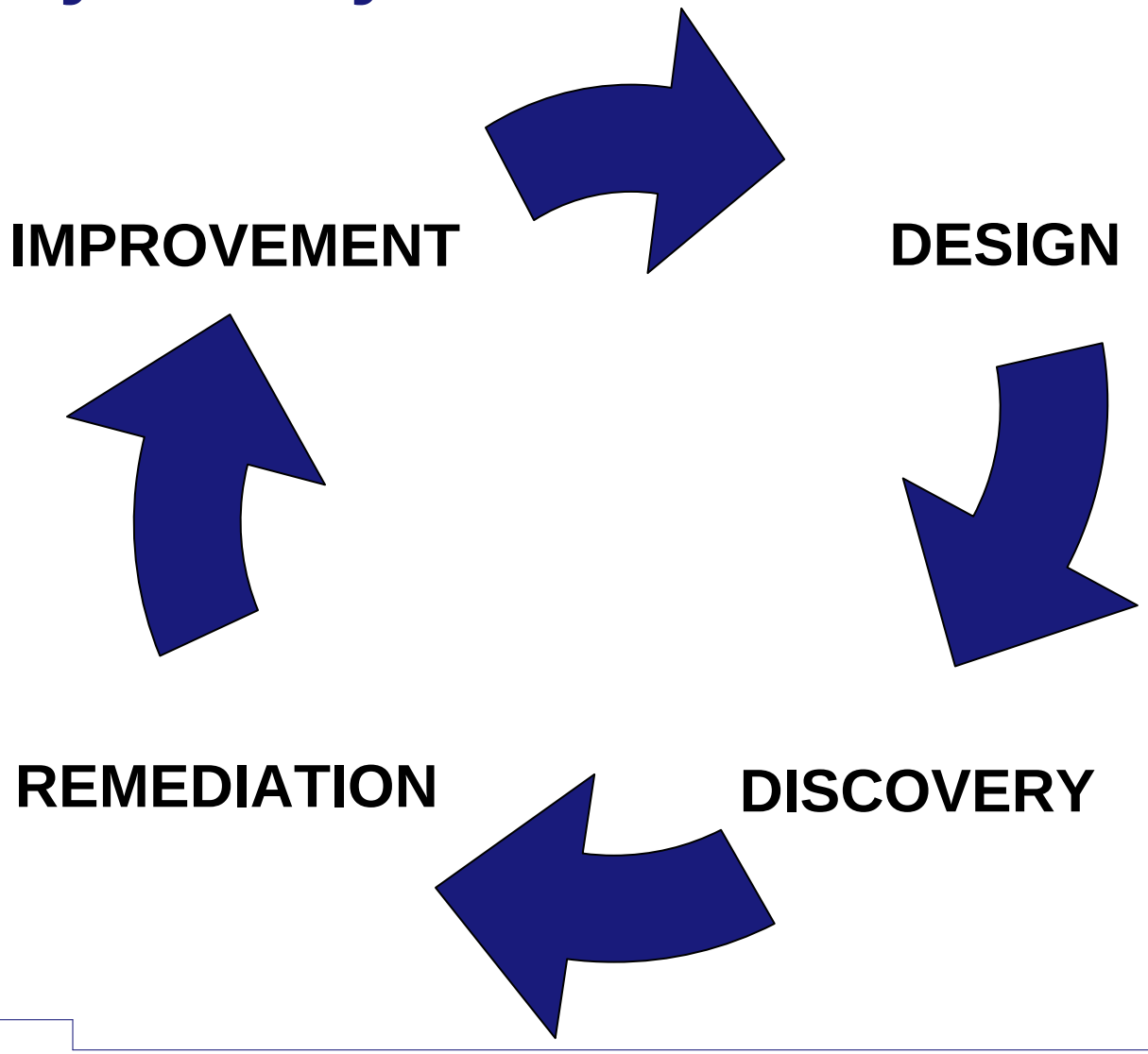
QMS Consistent with 1915c Appendix H

- Tied to the Federal Assurances
  - Level of Care
  - Plan of Care
  - Qualified Providers
  - Health and Welfare
  - Financial Accountability
  - Administrative Oversight by Single State Medicaid Agency
- Several Assurances have “components” or “sub-assurances”
  - How CMS operaltionalizes the assurances
  - QMS must address EACH component
- Evidence-based
  - Must “prove” to CMS through “evidence” that you are meeting the assurances
  - But, first and foremost, should be used to manage your program
  - Necessitates the collecting of information that is representative of the population
- Utilizes a continuous quality management approach

Quality Management Strategy

- Your blueprint for:
  - How you will *discover* when you are not meeting the assurances
  - How you will *discover* when you are not following program policies and procedures
  - How you will *discover* when you are not having good outcomes for program participants
  - How you will fix problems you uncover (*remediation*)
  - How you will improve your system so problems will not happen *(improvement*)

Quality Life Cycle – "DDRI"



The Quality Life Cycle – "DDRI"

- **Design (prevention, discovery, remediation mechanisms)**
  - Build in mechanisms to prevent "bad things" from happening
  - Build in mechanisms to identify "bad things" as soon as they happen
  - Build in mechanisms to address problems quickly
- **Discover**
  - Execute your plan to uncover "bad things" as they happen
- **Remediate**
  - Execute your plan to address problems in a timely fashion
- **Improve**
  - Learn from what didn't work and develop strategies for re-designing the system, if necessary.

Level of Care: *Persons enrolled in the waiver have needs consistent with an institutional level of care*

HOW DO I KNOW THAT ……

- An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future?
- The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver?
- The process and instruments described in the approved waiver are applied to determine LOC?
- The state monitors level of care decisions and takes action to address inappropriate level of care determinations?

How will you know?

- Discovery Processes
- How measure? Indicator(s)?
  - Source of information?
    - On entire population?
    - On a sample of the population?
      - How representative of the population is it?
- Frequency of report generation?
- Who will do what?
  - Collect the information
  - Aggregate the information
  - Review the information
  - Act upon the information (remediation, improvement)

Plan of Care: *Participants have a service plan that is appropriate to their need, and receive the services/supports specified in the service plan*.

HOW DO I KNOW THAT ……

- The state monitors SP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the SP development ?
- SPs are updated/revised at least annually or when warranted by changes in the waiver participant's needs?
- Services are delivered in accordance with the SP, including the type, scope, amount, duration, and frequency specified in the SP?
- Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers?

How will you know?

- Discovery Processes
- How measure? Indicator(s)?
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  - Act upon the information (remediation, improvement)

Qualified Providers: *Waiver providers are qualified to deliver services/supports*

HOW DO I KNOW THAT …

- The state verifies that providers meet required licensing and/or certification standards and adhere to other state standards prior to furnishing waiver services?
- The state verifies on a periodic basis that providers continue to meet required licensure and/or certification standards or adhere to other state standards?
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements?
- The state identifies and remediates situations where providers do not meet requirements?
- The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver?

How will you know?

- Discovery Processes
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  - Act upon the information (remediation, improvement)

Health and Welfare: *Participants' health and welfare are safeguarded and monitored; when problems arise they are addressed.*

HOW DO I KNOW THAT …

- There is continuous monitoring of health and welfare of waiver participants and remediation actions are initiated when appropriate?
- The state, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation?

How will you know?

- Discovery Processes
- How measure? Indicator(s)?
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Financial Accountablity: *Claims for waiver services are paid according state payment methodologies.*

HOW DO I KNOW THAT ….

- Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified providers in accordance with the approved waiver?

How will you know?

- Discovery Processes
- How measure? Indicator(s)?
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Administrative Oversight: *The State Medicaid agency is involved in the oversight of the waiver, and is ultimately responsible for all facets of the waiver program.*

HOW WILL I KNOW THAT …

- The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities?

How will you know?

- Discovery Processes
- How measure? Indicator(s)?
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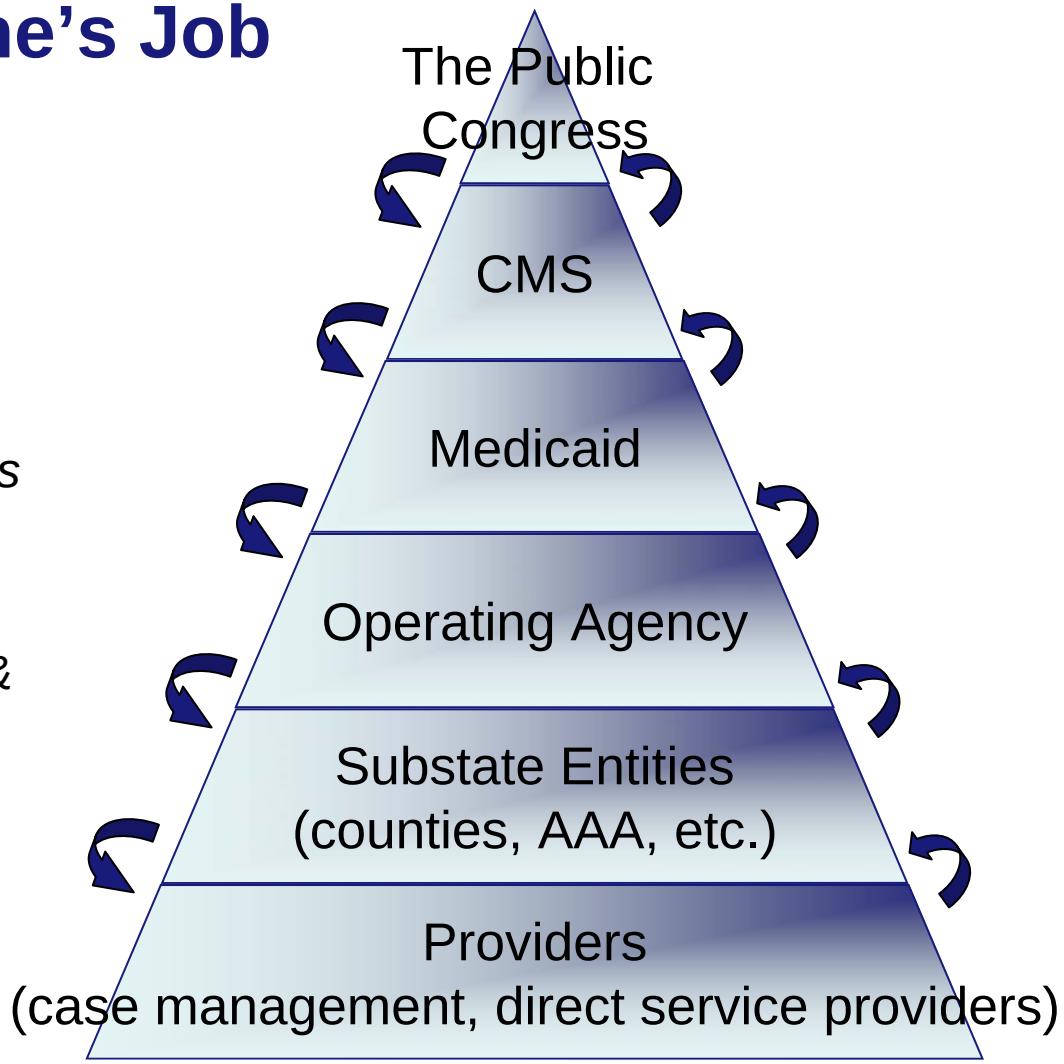
Quality is Everyone's Job

- ***Each level:***
- *Collects information on indicators*
- *Aggregates information*
- *Analyzes for patterns/trends*
- *Reviews & analyzes previous level's trend identification, remediation, & follow-up*
- *Conducts further investigation as appropriate*



CMS's New HCBS Quality Initiative

- New Waiver Application (*The FRONT END)*
  - State must provide more information on the design its quality management system
  - When "bad things happen" how will state know about it in a timely fashion so it can address the problem?
  - What will be done to monitor the "system" on an ongoing basis? Who will do it?

- Yearly reporting on waiver quality to CMS – EVIDENCE (*The BACK END)*
  - New 373Q (Implementation Date TBD)
  - Detailed reports on whether waiver is operating as intended
  - Detailed reports on whether waiver is having good outcomes
  - Detailed reports on what state did to fix problems it discovered

- On-going dialogue between CMS and States about quality
  - Review of evidence
  - Conference calls, emails
  - On-site visits

In the "Interim"

- Before the 373Q is implemented
- Request from CMS on 'Evidence"
  - CMS sends states letter requesting evidence
    - For waivers expiring through 12/31/2009: 18 months prior to expiration
    - For waivers expiring 1/1/2010 and beyond: 24 months prior to expiration
  - State has 3 months to respond
  - CMS issues *draft* findings report (12 or 17 months prior to expiration)
  - State has 1 or 3 months to respond
  - CMS issues final findings report (9 or 12 months prior to expiration)

In the "Interim" – con't

- "Evidence"
  - Must be linked to each assurance/subassurance
    - 6 assurances (from the 1915c authority)
    - 18 subassurances (CMS' operationalization of the assurances)
  - Demonstrates that the state met the assurance;
    - Discovery Information
      - Representative of the entire waiver (participants/providers)
      - Indicators, metrics
        - Aggregate, summarized information
  - Demonstrates that state addresses problems when assurances not met
    - Remediation/Improvement Information
      - Actions taken to address problems discovered
      - Results of actions

24 Hour Back-up System

- What will be the back-up system for when services not available?
  - Must be in place 24/7
  - Must be in place for all services/providers
    - Direct service workers
    - Transportation
    - Equipment repair/replacement
    - Other critical health or supportive services
  - Which entity will be responsible for backup for which services?
    - Delegate to local entities?
  - Are back-up systems different for differing target groups?
- How will you know that the back-up system works as intended?
  - Plans for monitoring responsiveness and timeliness of local agencies to consumer calls
  - Track and document the number and type of participants' requests for critical back-up

Risk Assessment and Mitigation

- How will you assess the consumer's risk?
  - Health risks
  - Behavioral/metal health risks
  - Fragility of the informal caregiver system
- How will you address risk in the care plan?
- *How will you know* that your approach to risk assessment and mitigation is working?
  - What information will you collect to monitor risk assessment and mitigation?
    - Are risk assessments being conducted?
    - Are risk plans adequate and appropriate?
    - Are risk plans implemented and monitored by the case managers and transition coordinators (if appropriate)?
    - Are risk plans revised as risk changes?
  - Who will review this information and take action if remediation needed?

Incident Management System

- What critical incidents will you require to be reported?
- Who is required to report?
- What are the timelines for reporting?
- What is the mechanism for reporting?
- Who (entity/entities) will receive the reports of individual critical incidents?
- How will the reports be evaluated and investigated?
- What will be the timeframes for responding to critical incidents, including conducting investigations?
- Which state agency (or agencies) will be responsible for overseeing the reporting of and response to critical incidents? How will this oversight be conducted, and how frequently?
- What information (reports) will you generate to assess whether your incident management system is working as specified? How frequently? Who will review them and act upon them in the event that remediation is needed?

Accessing Quality TA for MFP

- Needs Assessment
  - Over the next couple of months
  - Conference call with Thomson Healthcare staff
- If you need TA in Quality before the Needs Assessment
  - Quality Operational Protocols especially
  - Contact Beth Jackson, Thomson Healthcare
    - 617-492-9326
    - beth.jackson@thomson.com
- Waiver Application and Instructions/Technical Guide
  - http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp#TopOfPage
- Other resources on CMS website
  - www.cms.hhs.gov,
    - click on Medicaid
    - click on Medicaid Quality Initiatives
    - click on Home and Community Based Services